Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RONALD CORLEY

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-13-3053-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was reduced in error. This claim was for a Division ordered Designated Doctor Re-Exam. We billed a total of $1,875.00 for this claim but were paid $514.73. the explanation given on the EOB justifying the denial states: *PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES; CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICAITON,* however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32.."

Amount in Dispute: $262.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 26, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 08, 2012	CPT Code 99456-W6-RE (Extent of Injury Exam) and 99456-W9-RE (Other issues similar exam)	$262.50	$262.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. Labor Code §408.004 sets out provisions related to required medical examinations.
4. Labor Code §408.0041 sets out provisions related to designated doctor examinations.

5. Labor Code §408.151 sets out provisions related to medical examinations for supplemental income benefits.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - 16 – Claim/service lacks information which is needed for adjudication
    - 59 – Processed based on multiple or concurrent procedure rules

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. Did the respondent support the insurance carrier's reasons for reduction of payment?
3. Is the requestor entitled to reimbursement?

Findings

1. The disputed services relate to a designated doctor examination to determine extent of injury and other similar issues, with billing and reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(i)(1), which requires that "Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: . . . C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6 and (F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W9." §134.204(i)(2) further specifies that "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section."
2. Review of the submitted documentation provided finds a designated doctor examination requested to address extent of injury and other similar issues performed on November 08, 2012. Division notes reviewed shows division approved the examination for the service date performed November 08, 2012, to address only extent of injury and other similar issues under one examination.

   The insurance carrier denied service date November 08, 2012 with reason code 16 – "Claim/service lacks information which is needed or adjudication and 59 – "Processed based on multiple or concurrent procedure rules." The insurance carrier's payment reduction reason is not supported.

3. Per 28 Texas Administrative Code §134.204(k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports." Reimbursement for procedure code 99456-W6-RE and 99456-W9-RE is $500.00. The insurance carrier paid $325.00 for CPT Code 99456-W6-RE and $162.50 for CPT Code 99456-W9-RE, leaving a balance due to the requestor of $262.50. The requestor is therefore entitled to additional reimbursement of $262.50.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $262.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $262.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/15/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.